# A Healing Place Wheaton, IL

**INFORMATION FOR YOUR PHYSICIAN** Referred by: Today's Date:

| | | | |
|---|---|---|---|
| Name: | Age: | Date of Birth: | |
| Address: _____ Street | City | State | Zip |
| Home Phone: ( ) | Work Phone: ( ) | | |
| Marital Status: S ☐ M ☐ D ☐ W ☐ | No. of Children: | SS#: | |
| Present Marriage: (yr. married) | Previous Marriage: (yr. & duration) | | |
| Occupation: | How Long: | Employer: | |
| Education: (Highest Level Attained) | | | |

**MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU:**

| COMPLAINT | SINCE | CAUSE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?**

| MEDICATION | SINCE | ADVERSE EFFECTS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**List Any Allergies:** _____

HAVE YOU TAKEN CORTISONE TYPE DRUGS? YES or NO BIRTH CONTROL PILLS? YES or NO

HAVE YOU HAD A TRANSFUSION? YES or NO IF YES, GIVE DATE: _____

**WHAT OTHER TREATMENT/REGIMES ARE YOU CURRENTLY FOLLOWING?**

| TREATMENT/REGIME | SINCE | RESULTS |
|---|---|---|
| | | |
| | | |

**WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Abscesses | | Alcoholism | | Allergies | | Anemia | | Arthritis | |
| Asthma | | Bleeding | | Cancer | | Chicken Pox | | Cold Sores | |
| Depression | | Diabetes | | Emphysema | | Epilepsy | | Gall stones | |
| Goiter | | Gonorrhea | | Gout | | Hay Fever | | Heart Disease | |
| Hepatitis | | Herpes | | Jaundice | | Influenza | | Kidney Disease | |
| Leukemia | | Malaria | | Measles | | Miscarriage | | Mono | |
| Mumps | | Parasites | | Peritonitis | | Pleurisy | | Pneumonia | |
| Prostatitis | | Rheumatic Fever | | Rubella | | Scarlet Fever | | Sexual Abuse | |
| Skin Disease | | Strep Throat | | Sinusitis | | Stroke | | Sunstroke | |
| Syphilis | | Tonsillitis | | Tuberculosis | | Typhoid Fever | | Venereal Warts | |
| Warts | | Whooping Cough | | Worms | | Yellow Fever | | | |
| Pelvic Inflammatory Disease | | | | | | | | | |

**ANY OTHER MAJOR CONDITIONS**?_____

Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Which ones? _____

_____

"I,_____ have received a copy of *A Healing Place's* **Notice or Privacy Practices.**

Signature (Parents signature-on peds form)_____ Date_____

## WHAT OPERATIONS HAVE YOU HAD?

| OPERATION | WHEN | COMPLICATIONS |
|---|---|---|
| | | |
| | | |
| | | |

## WHAT MAJOR INJURIES HAVE YOU HAVE YOU HAD?

| INJURY | WHEN | LONG TERM EFFECTS |
|---|---|---|
| | | |
| | | |

Age of First Menses:_____ First Day of Last Menses:_____ Menses are regular: Yes ☐ No ☐
Number of Pregnancies: _____ Number of Miscarriages: _____
What immunizations have you had? _____
Any adverse effects from them? _____
Any prolonged courses of antibiotics? _____ Why? _____ Any adverse effects? _____
Have you lost weight lately? _____ How many pounds? _____ Present weight: _____
What exercise do you do and how much? _____
Any dental problems now? _____

## HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING?

| | | |
|---|---|---|
| TOBACCO | | ALCOHOL |
| COFFEE | TEA | RECREATIONAL DRUGS |

## INDICATE BELOW, WHICH OF THE FOLLOWING AILMENTS OR ANY OTHER MAJOR AILMENTS, HAVE AFFECTED YOUR BLOOD RELATIVES

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcoholism | | Allergies | | Arthritis | | Asthma | | Cancer | | Depression | |
| Diabetes | | Epilepsy | | Gonorrhea | | Gout | | Hay Fever | | Heart Disease | |
| Insanity | | Paralysis | | Pneumonia | | Skin Disease | | Syphilis | | Tuberculosis | |

| RELATIVE | AGE IF ALIVE | AGE AT DEATH | AILMENTS |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Brothers | | | |
| Sisters | | | |
| Children | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Maternal Aunts/Uncles | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |
| Paternal Aunts/Uncles | | | |

## ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN(S)?

| PHYSICIAN | FOR WHAT CONDITIONS? | TREATMENT? |
|---|---|---|
| | | |
| | | |

## HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE?

| PHYSICIAN | FOR WHAT CONDITIONS? | WHEN? |
|---|---|---|
| | | |
| | | |
| | | |